REVIEW

Memory clinics

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Postgrad Med J 2006;**82**:199–206. doi: 10.1136/pgmj.2005.040592

Memory clinics were first described in the 1980s. They have become accepted worldwide as useful vehicles for improving practice in the identification, investigation, and treatment of memory disorders, including dementia. They are provided in various settings, the setting determining clientele and practice. All aim to facilitate referral from GPs, other specialists, or by self referral, in the early stages of impairment, and to avoid the stigma associated with psychiatric services. They bring together professionals with a range of skills for the benefit of patients, carers, and colleagues, and contribute to health promotion, health education, audit, and research, as well as service to patients.

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Submitted 17 August 2005
Accepted
5 November 2005

When Morris Fraser provided a chapter about ''Memory clinics and memory training'' for Tom Arie's second edition of recent advances in *Psychogeriatric Medicine*,[1] he referred to publications from the 1980s, which described clinics established in the USA. They were part of a tradition, common through Europe as well as North America, which saw expertise available only within specialist centres: hospitals and particularly university hospitals. This contrasted with the psychogeriatric movement that developed in the UK, which took expertise to patients and families in their own homes, working closely with them and other agencies to maintain and repair their potential strengths with minimal disturbance.[2 3] It was, and is, essential in this ''social psychiatry'' model, that due respect be paid to a comprehensive assessment of the person, including their physical and mental health status. Much can be done within the home and in association with the primary care physician, although recourse to further clinic based investigation is often useful.[4] Thus the two movements can be seen as complementary rather than competitive from the start.

Fraser listed the objectives of memory clinics as:

(1) To forestall deterioration in dementia by early diagnosis and treatment.
(2) To identify and treat disorders other than dementia that might be contributing to the patient's problems.
(3) To evaluate new therapeutic agents in the treatment of dementia.
(4) To reassure people who are worried that they might be losing their memory, when no morbid deficits are found.

These remain among the main objectives and raisons d'etres of memory clinics, although others have been added.[5] His description seems to assume that memory clinics would restrict their interest to the diagnosis and treatment of dementia, although memory is affected in other disorders.[6] In practice, most people presenting with memory problems are, indeed, suffering from dementia, and it is for this condition that most clinics have greatest expertise and have developed useful links with other agencies. This is a potential problem for people with less common conditions.

CURRENT STANDING AND DISTRIBUTION

In response to the enthusiasm and publicity generated from pioneer clinics, their work has been replicated, developed, and reported in many countries.[7–28] The European tradition of clinic based neuropsychiatry has found the concept particularly attractive,[23–26] but examples are described from the French speaking community, North America, Australasia, and many other parts of the world. In some countries, including the UK, networks of clinics have come together in associations to share experiences and spread good practice.[24 27 29] Most clinics are associated with mental health services or centres, often with specialist services for older people.[30] Some are based within a hospital or service working with physically ill (usually old) people, and a substantial minority are within a neurology centre.[7 31–34] These differing settings are reflected in varying characteristics of clients, differences in the activities undertaken within the clinic, relationships with other agencies, and outcomes and follow up expectations.[7–9 35–42] A few clinics have been established to meet the needs of particular client groups including people with learning disability,[43] early onset dementia,[44] and special language or cultural needs.[45] Differences are found between clinics serving urban and rural communities in the USA.[53]

James Lindesay and his colleagues in Leicester have become recognised diarists of the UK scene. Tracing a mere 20 clinics for their 1995 report,[47] they identified 102 in preparing the 2002 sequel but obtained information from only 72 and 14 of these were no longer active. This reflects a changing, remodelling scene, not one of simple expansion.[30] The UK is unique in being the birthplace of the international psychogeriatric movement, having a recognised specialty of old age psychiatry, and a nationwide system that provides specialist services for older people with mental health problems within the NHS.[48] It has probably gone further than other countries in attempting to offer specific special services for younger people with dementia.[49] Thus the

emerging experience and roles of memory clinics in the UK are of special significance.

WHAT IS DONE IN MEMORY CLINICS?

Accounts of the work of memory clinics are available from a number of books, chapters, and individual journal articles.[5 22 30 32 37 39 40 50–57] Although early clinics may have devoted themselves to research, this is true of very few that have survived.[30 56 57]

The essential components of a memory clinic include:

A place

It is important that a place, situated within easy access of the population to be served, is identified and appropriately equipped. Phipps and O'Brien point out that one of the disadvantages of the intense swing toward home visiting in the UK, has been lack of investment in buildings suitable for the conduct of outpatient work.[58] An alternative view might be that this is a cost saving, advantage of the system. But setting aside space: properly proportioned rooms to allow the accommodation of several members of staff of different disciplines to conduct their clinical work with patients and carers in private is a ''must have''. Rooms require furniture, heating, lighting, and communications and some staff will need special equipment. They must also be quiet and lacking in distractions. There is need too, for suitable communal areas, to allow for the reception of patients and families and for them to be comfortable while awaiting involvement assessments or other activities. There is requirement for rooms big enough to allow the team of staff to come together to discuss their findings and make plans and to share these with patients and carers. Throughout it is important that refreshments are available together with access to toilets and bathing facilities if need arises. Transport to and from the clinic may be achieved by the family but may require special arrangements. Some patients or carers may be disabled physically.

Suites of rooms such as this may be available in health centres, general hospitals, community hospitals, day hospitals, or other premises. Little has been written on design for such clinics, in contrast with the extensive literature on design for long term care facilities for people with dementia. It is unlikely that a full suite of rooms will be devoted exclusively to memory clinic functions, but time can be allocated for this purpose in a multi-user programme.

Key staff, however, will require to be accommodated at other times and to store and access records and other key materials whenever needed.

Time

Memory disorder, once established, particularly when consequent upon dementia, is usually present 24 hours of every day. Problems or anxieties arising from it may occur at any time. Comprehensive services must, therefore, be available to the same calendar. Most memory clinics restrict their full availability to one or two days each week. Key clinic staff may remain involved with memory clinic activity through the working week, while other staff will be active in other settings and other tasks. Thus it is important that the clinic has good links with community services, giving and receiving information. The 24 hour availability of an answerphone, with response from key staff at the beginning of each working day is helpful and reassuring to all parties.

Early ambitions

- Early diagnosis and treatment of dementia.
- Early diagnosis and treatment of other memory problems.
- Evaluation of therapies.
- To reassure people who fear their memory is failing, when it is not.

A team

Successful clinics require a core team of a clinician or clinicians, often a senior nurse, supported by secretarial time. These people will devote all or a substantial proportion of their time to the clinic and its functions; preparing paper work, organising transport, investigations, gathering extra information, answering queries, throughout the week. They then set up colleagues to make optimal use of their time and skills on main clinic days, when patients and carers are in attendance at the clinic. Between times they need to work through community mental health teams, in addition to undertaking some home visits themselves.

Specialist input comes from:

- Medical staff: the lead consultant may be a physician, neurologist or psychiatrist, trainees, non-consultant career grade doctors or physician assistants may be involved. Students find attendance helpful.
- Clinical psychologists: the lead clinical psychologist may be the clinic director. They are likely to be supported by colleagues and trainees and may involve students.
- Nursing staff: often provide the continuity of care throughout the week, linking with other components of the service.
- Alzheimer's Society liaison: regular attendance has multiple advantages for promoting links for patients and families and for providing reassurance from a lay expert-by-experience during the clinic days.
- Social work: is usually provided through community mental health teams.
- Occupational therapists: often a regular member of the clinic team. Sometimes accessed on a needs basis.
- Speech therapist: sometimes a regular member of the team, otherwise accessed when needed.
- Dietitian: few clinics will afford the regular presence of a dietician; they will usually be accessed on a consultation basis.
- Clinical pharmacologist: probably consulted rather than involved routinely.

Links to other expertise including chiropody, dentistry, hearing, and eyesight clinics are important.

Some clinics have access to in-house language experts, others require to access translator facilities.

Some clinics are promoting links with faith leaders and faith communities.

Some clinics have access to the expertise of alternative therapists

MEDICAL ASSESSMENT

It is understood that the dementia syndrome can be the symptomatic result of a number of organic pathologies acting singly or in combination. It is accepted, therefore, that everyone developing a memory problem requires a full review of their general health, including history, physical examination, consideration of medication, and investigations to establish a diagnosis and clarify all contributing factors.[59]

Some clinics will arrange for some or all components of this to be undertaken by the referring clinician, who may be a general practitioner or hospital doctor or specialist. Others will prefer to under take a full review themselves, or to add

supplementary inquiries, examinations, or investigations where these are indicated. What is important is that a comprehensive review is completed and, recorded in the notes and shared with the patient and their primary care physician and the referring agent.

In addition all patients should receive a full review of their mental health including history and mental state examination. This requires review of relevant previous notes where these are available and history and description of current behaviour and problems from a carer, often from the family. Sometimes memory disorder is a function of changed mood or other neurotic or psychotic ideation. On other occasions, a dementia is complicated by the presence of ''non-cognitive'' symptoms of mood, perception, belief, or behaviour.[59]

PSYCHOLOGICAL ASSESSMENT

Psychological assessment may be conducted by a clinical psychologist. In many clinics, however, basic assessments are undertaken by other staff, preferably with the support and supervision of a senior clinical psychologist. These assessments are framed around a clinical appraisal and make use of validated instruments designed to measure aspects of cognition and non-cognitive function. The Manchester group has reviewed current practice in the use of rating scales in the UK,[55] individual clinics develop their own preferred schedules and these evolve over time.[5 32 50–52] Several reports point out that diagnosis of dementia is not a difficult task in most instances, and the simplest, shortest schedules are as effective as the longer, more complex ones when the outcome required is allocation to a crude diagnostic group. The advantage of the more detailed and structured scales is their ability to reflect more sensitively the particular strengths and weaknesses exhibited by a person.[55 59–62] This makes it possible to understand and explain their difficulties and associated functional or behavioural change. It also makes it possible to work with the person and their carers to plan and explore strategies to cope with the deficits. The longer and more complex schedules may be helpful when differential diagnosis is difficult or contains elements of several psychopathological processes.

SOCIAL ASSESSMENT, INCLUDING A CARER'S PERSPECTIVE

Basic information about each patient's social circumstances will be collected as a matter of routine within clinics. Memory problems, especially when arising from dementia, leave people compromised and dependent on others for help in organising their lives and keeping safe. Families and other informal carers contribute a great deal to keeping them well and safe.[63] Even in the early phase of impairment, it is important to register who is doing what and what potential gaps remain or look likely to develop. Key carers may have health problems of their own and may have responsibilities to others who need their help.[64] Some are committed to paid employment. If or when impairment progresses, it is usually necessary to supplement informal care with support through social services or other agencies. Few clinics will include a social worker among their core staff but they will liaise with social workers or others to complete more complex assessments of need and ensure that appropriate support is made available in response to changing needs. Such assessments extend to cover the needs of informal carers.[64] This is done, in part out of respect for the carers, but also in appreciation that living with dementia is a challenge to the whole family. Optimal care of the person with dementia, and optimal use of care resources, is more likely if attention is paid to the whole family/caring unit rather than its parts.[65] Sharing of information between agencies contributing to a single assessment process is encouraged, and memory clinics can play a useful part in this.[66]

Settings

- Psychiatry, especially old age psychiatry: research and service profiles.
- Neurology: high proportion with mild or no impairment and symptomatic impairment.
- Geriatric medicine and old age psychiatry: few with symptomatic impairment.
- Primary care: emerging possibility.

FUNCTIONAL ASSESSMENT

Function may be compromised across a range of activities, from the most subtle to the most basic. Appreciation of the loss of some skills and the preservation of others, emerges from all aspects of a multidisciplinary assessment. Codifying and giving measurement to a functional profile, from which rehabilitative and therapeutic programmes may be constructed, is best undertaken by an occupational therapist attached to a clinic. A number of valid and reliable scales are available and made use of, although all have their limitations.[67] While impairment of cognition in itself and its effect upon interpersonal communication, may be of the greatest significance to patients and clinicians, it is the impact on function and the associated need for costly social prostheses, which impresses others.[68]

LEGAL CONSIDERATIONS

Preserved intelligence underpins competence to undertake a range of responsibilities. These include: the management of monies, the preparation of wills, consent to treatment, change of accommodation or other intrusions from others, entry into a contract of marriage, continued licence to drive.[69]

Clinics are likely to receive requests to advise on any of these.

SPIRITUAL MATTERS

Spiritual aspects of healthcare, particularly in association with chronic illness and terminal care, are belatedly receiving the attention they deserve.[70] Dementia has implications for the spiritual and faith lives of both patients and carers. Clinics are beginning to explore how to make themselves competent in approaching these issues and making appropriate response.[71]

MEDICAL INTERVENTIONS

Assessment and investigation will usually determine a diagnosis and contributing factors. They may identify treatable physical or psychiatric disorder.[59] This may be done within the clinic or require referral to colleagues. Treatment of non-cognitive symptoms with psychotropic drugs has long

Essential attributes

- Dedicated time
- Dedicated space
- Dedicated core team
- Committed expertise of other disciplines
- Effective links with other agencies
- Involvement of local Alzheimer's Society

been possible and remains an important contribution for patients with dementia or other conditions. Care has to be taken because unwanted effects of medicines are not rare.[72]

The advent of effective and non-toxic ''antidementia'' drug treament has transformed the prospects for people with Alzheimer's disease and Lewy body dementia and is acknowledged as the main reason for the increased investment in memory clinics. Lindesay identifies this as the main driver for the creation of clinics with service, rather than research, ambitions.[30 73 74]

Treatment for vascular disorders underlying vascular and other dementia, is generally seen to be the responsibility of other clinicians, although the Alzheimer's Society is campaigning to emphasise the importance of vascular disease in the genesis and progress of dementia. This may lead clinics to take more interest in this phenomenon and to liaise more energetically with vascular services.[75]

PSYCHOLOGICAL INTERVENTIONS

Memory clinics have been a factor in encouraging more clinical psychologists to work with older people, and people with dementia. Beyond their contributions to assessment, they work with patients, families, and groups to identify and share information about approaches that maximise use of retained cognition and minimise the emotional distress that can come from frustration and misunderstanding, and that impair performance even further.

Reminiscence therapy, validation therapy, reality orientation, music therapy, art therapies, exercise therapy, pet therapy, and other approaches all have their champions and their roles.[59]

ALTERNATIVE THERAPIES

Beyond the medicines of the pharmacopoeia, traditional herbal remedies and aromatic oils show some promise in improving memory disorders or their associated non-cognitive symptoms and are not shunned by clinics.[76] Massage, multi-sensory stimulation (Snozelen), and aromatherapy are used with apparent benefit.[59 76]

SOCIAL INTERVENTIONS, INCLUDING HELP AND SUPPORT FOR CARERS

Support within the home, offers of stimulating or restful activities, or changes of accommodation, are usually provided through other agencies, but the clinic may draw attention to needs, make useful suggestions for initiatives, and monitor their impact. There is growing interest in the use of new technology to complement traditional personal care systems.[77]

Essential activities

- Assessment and investigation
- Consideration and discussion of diagnosis and differential diagnosis
- Sensitive communication of conclusions and their implications to patients and family carers
- Exchange of information with other agencies and contribution to ongoing care
- Development and provision of therapies
- Monitoring of progress and response to therapy
- Education: patients, carers, trainees, colleagues, and the general public.
- Health promotion
- Audit and research.

One particular activity that may be centred on a memory clinic is a regular support group, either for carers or for patients, sometimes alternating with carer-patient couples.[78]

LIAISON WITH OTHER AGENCIES

Memory clinics function optimally when they network effectively with other components of the overall social and health care system within a locality. What is required is that the whole system works well for patients, each component understanding and respecting the strengths and weaknesses of the others. There has to be some overlap in what the several units do, omissions in the range of needs provision should be avoided. In sharing information about patients with them, their family, and with other agencies, a balance is needed to maintain respect for privacy and openness, and to avoid unnecessary duplication of effort or mismanagement through ignorance of what is already known. There are strong arguments for maintaining continuity of care through the primary care team, who are likely to know the patient, the family, and other local resources better than other agencies. Some practices have successfully pioneered the use of patient held records for older people who are at risk because of memory impairment (Ian and Nicola Greaves, personal communication).

APPROACHES TO REHABILITATION

Dementia is a disabling condition. Periods of crisis or of inappropriate care are followed by secondary and tertiary impairments. It is dangerously easy for these to be accepted as inevitable and irreversible consequences of the condition. The skills of a memory clinic may identify and differentiate the essential from the recoverable phenomena. Recovery of some abilities is not impossible and leads to a happier, less restricted, less expensive lifestyle.[79]

EDUCATION AND TRAINING

Memory clinics offer an ideal venue for teaching, bringing students, and postgraduates of any particular discipline into contact with patients, carers, and the several professions of the multidisciplinary team. An additional educational role relates to patients and carers themselves. It is much more useful to involve them in structured learning programmes than simply provide written or taped materials for them to read alone. Questions and answers, complemented by discussions within the group make a more meaningful and enduring impact.

Education and training for colleagues within the professional care system is something that memory clinics may organise or simply contribute to. There is much evidence that such programmes are needed to improve awareness about dementia and related disorders, their identification, and best management.[80 81]

Some services will offer open lectures to bring information to the general public.

HEALTH PROMOTION

The promotion of health, be it primary and attempting to avoid the genesis of illness, or secondary or tertiary, aiming to reduce the impact of illness once developed, is integral to the approach taken in all National Service Frameworks.[82–84] Much is now understood about the factors associated with the development and progress of dementia. Programmes of health education, as outlined above, can be linked to programmes designed to help patients improve their general health, reducing the risk of developing dementia, or managing their lifestyle when symptoms have begun, so that secondary complications and distress are reduced to a minimum.[85] Clinics attract the depth and breadth of knowledge that can generate and sustain such programmes.

RESEARCH AND AUDIT

The first clinics have been caricatured as research enterprises within centres of excellence.[30 47 53 56 57] This tradition remains and is worthwhile. In addition the rigour of good practice and systematic collection of data fostered in routine service orientated clinics provides an excellent basis upon which service research and audit can be conducted.[53 86–88] This allows new approaches to be explored and evaluated, with less disruption for persons (patients and carers and professionals) and systems, than might be needed elsewhere. Certainly, clinics have been used more effectively to this end than the otherwise more advantageous domiciliary services.

FOLLOW UP/FOLLOW THROUGH TO DEATH AND BEYOND

Many clinics restrict their involvement to the assessment and treatment of patients early in their careers with dementia. Longer term follow up falls to community mental health teams or primary care. If patients move into an independent sector nursing home, it is not unusual for them to be lost to follow up all together. This is a pity. It seems, indeed, to be a travesty that the neglect of people dying within 50 bedded wards in county asylums has given way to neglected deaths in private nursing homes.[81] Some clinics do maintain an involvement directly, or indirectly through the local community service. Their interest may be limited to further, postmortem, biological studies. It would be good if the expertise of clinics could be recruited in support of efforts to improve care, including care as death is near, in the last phases of the illness and the support of families thereafter.[89]

WHAT IS ACHIEVED BY MEMORY CLINICS?

Clinics see patients, usually along with a family member or carer. The clinic staff may have seen the patient at home before their attendance and may see them elsewhere, in follow up. In most instances attendance follows a referral from another doctor or agency. Most reports suggest that this process facilitates early detection of dementia or a related condition.[10 13 18 20 23 54 62 90 91] In at least one study GPs were satisfied with the response they received concerning assessment, investigation, and diagnosis and the communication to them about these. They were less impressed with advice about future care options and family support.[92] Users and carers are not always so pleased with the clarity of information given to them about the assessment and diagnosis, nor about the advice given to carers.[11 93] Indeed, although almost all carers and patients express the view that they should be given a diagnosis,[13 14] for some the diagnosis and its implications are received as an unwelcome surprise.[94] Many people come to clinics with very limited knowledge of dementia and what they might expect from their assessment.[95] This means it is important to tailor the content and form of communication to individuals. There is no effective alternative to devoting time to this exercise, for it is extremely important that everyone concerned has an understanding of what is being done in the assessment process and why; and what the findings and conclusions are and their implications for the future. Standardised information sheets and similar materials have a part to play, but are supplements to dialogue rather than replacements. Some clinics dignify communications as ''pre-'' and ''post-'' diagnostic counselling sessions. Our own experience is that patients and families do appreciate the availability of the clinic and the time and space that it offers to consider and discuss matters with staff, Alzheimer's Society liaison worker, and with other families. This appreciation extends to the families of the Punjabi speaking minority population in Wolverhampton. They often seem to be particularly at ease in the clinic format with the opportunity to ask questions and to receive written materials about the condition and services. It is essential that staff are prepared to revisit questions and answers, for learning in this context is iterative. There is so much to take in and so much emotional resistance to some messages, that a ''once and for all time'' approach is not appropriate.

WHAT DO MEMORY CLINICS CONTRIBUTE TO THE OVERALL CONTEXT OF CARE?

Published reports concentrate almost exclusively on the activities of a clinic as an entity that receives referrals, undertakes assessments of the people referred, and sometimes their carers, offers some kind of intervention, and then either does or does not follow them up for a period of time. It is a common aim of clinics to be available and attract people to come for help before their problems have become too advanced.[1 10 30] One of the boasts of such clinics, has been that they see people who are less impaired than those engaging with the community old age psychiatry service. This was certainly being achieved in the research clinic described from the Maudsley Hospital in the 1980s[57] and the mixed purpose clinic in Newcastle of the 1990s.[54] Patients attending these clinics were younger, less cognitively impaired, and had a shorter duration of symptoms than patients cared for within the mainstream community services. Phipps and O'Brien[58] present a vision of quality and clinical governance, applicable to memory clinics, which rests on their ability to attract people with very mild ''pre-dementia'' impairment. Their assessment should be in ''pleasant, accessible, convenient, quiet and spacious accommodation''. European studies suggest that the presence of a memory clinic facilitates early referral and goes someway to combat stigma against involvement with psychiatric services.[10] Simpson's clinic,[53] however, embedded within a non-academic service, sees a clientele that is similar in age, sex, social circumstances, and social class to that of the comprehensive service. His clinic patients received similar diagnoses and had similar levels of cognitive impairment to those seen through contact at home. They differed only in the relative absence of behavioural problems and other psychiatric symptoms in the clinic population.

Most clinics require that patients are referred from a medical source, be this a primary care physician or another specialist, although some clinics permit or encourage self referral.[96] This latter approach certainly aims to reduce stigma and to reduce barriers or filters, which might delay early contact. It risks skewing the clientele and use of resources to the ''worried well'' with little cognitive impairment of organic origin. Analysis of the diagnostic profiles seen by different clinics is revealing: clinics based within old age psychiatry or geriatric medicine find that almost all their patients have a mainstream dementia, with few of them having possible or practicable prospects of resolution.[39] Nevertheless associated physical problems may be usefully identified and/or drug regimens reviewed. People referred to research, self referral, or neurology based clinics are likely to present with a larger range of disorders, with up to 30% having no objective evidence of memory impairment.[7] There is a literature of these cognitively intact memory clinic clients. Many have symptoms of anxiety or depression and a number carry a family history of dementia. Identification and treatment of their symptoms gives an additional role to the psychiatrist attached to such clinics.[38] Follow up studies suggest that a proportion of these people go on to develop objective evidence of memory impairment.[37]

Challenges remain not only to encourage populations as a whole to seek early contact with expertise, which may be helpful, but also to achieve equity in access to such expertise. Ethnicity, language, and location may all, individually or in combination reduce the likelihood of early contact.[18 45 46]

Five key references

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Much less is written about the role and contribution of clinics in the long term experience of dementia by patients and their families and the other agencies contributing to their care. There are publications reflecting the comments of GPs and patients on the outcome of assessment visits,[46] but little or nothing on interactions thereafter. Papers considering the differences between memory clinics and community services have hardly begun to explore the flow of people, or information about them between these two components of service.[53 54] Still less is there information concerning the impact of clinics on, or interaction with, services provided by other agencies such as general hospitals, social services, the voluntary or the independent sectors. This is a significant gap in understanding, for these agencies play big parts in the overall care of people with dementia and the support of their families.

ARE MEMORY CLINICS WORTHWHILE AND VALUE FOR MONEY?

There is general acceptance that memory clinics, when structured, resourced, and conducted properly, are desirable and add to the quality of services to people with memory problems, including that majority with dementia.[10 58] It is interesting that the recent review by the National Institute of Health and Clinical Excellence (NICE),[68] while questioning the cost effectiveness of the licensed, and previously approved, acetylcholinesterase inhibitors, made it clear that they were pleased that their earlier guidance had encouraged the spread of memory clinics. This is in keeping with the support for clinics enshrined within the National Service Framework (NSF) for Older People[84] and reports from the Audit Commission.[80] In fact there is little evidence regarding what the presence of a clinic within a comprehensive service actually achieves. The Cochrane database is silent on the subject. Thus it is interesting to know that new clinics are being established and others closed, presumably because they have been deemed less effective in practice than had been anticipated.[30]

It is interesting too, that the annual UK memory clinic conference has debated in successive years (2004 and 2005) the question: ''Do memory clinics have a key role in the management of dementia?'' Even among those expected to be most committed, there is a degree of uncertainty.[97 98] There are so many variants on the theme that it is not possible to provide an answer that applies to all situations. Given the range of interpretations, it would seem timely to commission a detailed description and costing of exemplar clinics, in the context of their overall local services. This is not an argument to enforce one pattern everywhere. Flexibility and best use of local resources should guard against a move to uniformity, but it should be possible to identify models of good practice and to estimate what each is likely to cost and achieve within the profile of a multi-agency service.

WHAT DOES THE FUTURE HOLD?

Memory clinics have shown themselves to be a good development. They are appreciated by patients and their families for they offer a forum within which more detailed in depth appraisal of patient needs can be explored and discussed. Each clinic is a local reference point to which anyone, professional, carer, or patient, can turn for support, information, instruction, and guidance on local, national and international best practice.

There remains much to be learned about their optimal use and in particular how they best contribute to the overall pattern of care in dementia and possibly other memory disorders.

There is a rapidly changing range of initiatives, which show promise in the treatment and management of memory disorders, and in the support of patients and families where they exist. For all of these, there is a need for research and evaluation and for training and education of staff and others in their application. Memory clinics provide a sound structure within which these activities can be undertaken.

ACKNOWLEDGEMENTS

We thank Michael Clark, James Lindsay, and Alistair Burns for helpful comments, and Ruth Jones for her secretarial skills.

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Funding: none

Conflicts of interest: none declared.

APPENDIX

There are many web sites on problems of memory and living with dementia. Many memory clinics offer information about their services from individual sites.

In addition to those included in the list of references, the following have something extra to offer and commend them:

http://www.dsdcengland.org.uk This recently developed site links the English Dementia Centres

http://www.dementia.stir.ac.uk Stirling is the original DSDC and this site provides links to all other UK centres

http://www.caregiving-solutions.com/rescen.html Provides links to memory clinics in the United States of America

http://www.brace.org/bmdcl1.html The important Bristol Clinic links other clinics in the UK

http://www.couragetocomeback.net/about_camh/multi-lingmem_btspring2004.html Focuses on the difficulties that compound problems for people with original language other than the main language of their country of residence

http://www.rice.org.uk/memory.htm The Bath clinic pioneered by Roy Jones and colleagues. It includes a nurse led community screening clinic.

http://www.alzheimers.org.uk/WordDocuments/.../Reading list_memoryclinics.doc Updated review of literature and other reports of innovations

http://www.ethnicelderscare.net/memoryclinics.htm Issues of minority populations

http://www.alzheimer-insights.com/insights/vol7no1/vol7-no1b.htm A primary care perspective on possibilities in dementia care

http://www.mhilli.org/network/specialistservices.htm Mental Health Foundation review of memory clinic prospects

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